

Effective Dates: January 1, 2025 – December 31, 2025

## Attachment A to Certificate of Coverage

The Plan's services and benefits, with its copayments/coinsurances and some of the limitations, are listed below. Please remember that this is only a brief listing. For further information, plan guidelines, and exclusions, please see the Certificate of Coverage.

**Please keep this Attachment A for your records.**

MEDICAL BENEFITS	COVERAGE
<b>PRIMARY CARE SERVICES:</b>	
<ul style="list-style-type: none"> <li>• <b>Preventive Care &amp; Other Office Visits</b> <ul style="list-style-type: none"> <li>▪ Routine Physicals</li> <li>▪ Covered Immunizations</li> <li>▪ Hearing Exams</li> <li>▪ Illness and Injury</li> <li>▪ Medical Physician Services</li> <li>▪ X-Rays</li> </ul> </li> </ul>	\$35 Copayment per visit
<b>SPECIALTY CARE:</b> <i>(No PCP Referral Required)</i>	
<ul style="list-style-type: none"> <li>• <b>Medical Physician Services</b></li> <li>• <b>Illness and Injury</b></li> <li>• <b>X-Rays</b></li> <li>• <b>OB/GYN Services</b> <i>(One OB/GYN preventive visit per Calendar Year)</i></li> </ul>	\$35 Copayment per visit \$35 Copayment per visit 100% Coverage \$35 Copayment per visit
<b>URGENT CARE CENTER SERVICES:</b>	
<ul style="list-style-type: none"> <li>• <b>Medical Physician Services</b></li> <li>• <b>Illness and Injury</b></li> </ul>	\$35 Copayment per visit
<b>LABORATORY PROCEDURE:</b>	
<ul style="list-style-type: none"> <li>• <b>Covered Genetic Testing</b></li> </ul>	\$5 Copayment per test 80% Coverage
<b>VISION CARE:</b> <i>(No PCP Referral Required)</i>	
<ul style="list-style-type: none"> <li>• <b>One routine vision exam every 12 months</b></li> <li>• <b>Other eye care office visits</b></li> </ul>	\$35 Copayment per visit \$35 Copayment per visit
<b>ALLERGY SERVICES:</b> <i>(No PCP Referral Required)</i>	
<ul style="list-style-type: none"> <li>• <b>Physician Services</b></li> <li>• <b>Testing</b></li> </ul>	\$35 Copayment per visit 80% Coverage
<b>DIAGNOSTIC SERVICES:</b> <i>(Including but not limited to CT Scan, MRI, PET/SPECT, ERCP)</i>	
\$250 Copayment per service	
<b>HOSPITAL SERVICES:</b>	
<ul style="list-style-type: none"> <li>• <b>Inpatient Services</b></li> <li>• <b>Outpatient Services</b></li> </ul>	\$600 Copayment per admission \$250 Copayment per visit
<b>MATERNITY SERVICES:</b> <i>(Covered for employee and employee's spouse; not covered for dependent children)</i>	
<ul style="list-style-type: none"> <li>• <b>Physician Services</b> <i>(Prenatal, delivery, and postnatal care)</i></li> <li>• <b>Maternity Hospitalization</b></li> </ul>	\$35 Copayment per delivery \$600 Copayment per admission
<b>Eligible baby must be enrolled in plan within 30 days of birth or adoption for baby's care to be covered.</b>	
<b>EMERGENCY ROOM SERVICES:</b>	
	\$125 Copayment per visit <i>(Copayment waived if admitted to the same hospital for the same condition within 24 hours)</i>
<b>EMERGENCY AMBULANCE SERVICES:</b> <i>(Must be Medically Necessary)</i>	
	70% Coverage
<b>DURABLE MEDICAL EQUIPMENT &amp; PROSTHETIC DEVICES:</b>	
	70% Coverage
<b>SKILLED NURSING FACILITY SERVICES:</b> <i>(100 days per Lifetime)</i>	
	100% Coverage
<b>MEDICAL NUTRITION SERVICES:</b> <i>(Limited to 6 visits per Calendar Year with a Registered Dietitian or Nutritionist)</i>	
	\$35 Copayment per visit
<b>DIABETES SELF-MANAGEMENT EDUCATION:</b>	
	\$35 Copayment per visit
<b>DIABETIC SUPPLIES:</b> <i>Insulin covered under prescription drug rider. For Diabetic Supplies call VIVA HEALTH.</i>	
	100% Coverage
<b>REHABILITATION AND HABILITATION SERVICES:</b> <i>Physical, Speech, &amp; Occupational Therapy and Applied Behavior Analysis (Limited to 60 total inpatient days and 30 total outpatient visits per Calendar Year for medical diagnoses)</i>	
	80% Coverage
<b>HOME HEALTH CARE SERVICES:</b> <i>(Limited to 60 visits per Calendar Year)</i>	
	100% Coverage
<b>CHIROPRACTIC SERVICES:</b> <i>(No PCP Referral Required. Covered up to 25 visits per Calendar Year.)</i>	
	\$35 Copayment per visit
<b>TEMPOROMANDIBULAR JOINT DISORDER:</b>	
	\$35 Copayment per visit
<b>SLEEP DISORDERS:</b>	
<ul style="list-style-type: none"> <li>• <b>Sleep Study</b></li> </ul>	\$250 Copayment per sleep study
<b>TRANSPLANT SERVICES:</b>	
	\$600 Copayment per admission
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES:</b>	
<ul style="list-style-type: none"> <li>• <b>Inpatient Services</b></li> <li>• <b>Outpatient Services</b></li> </ul>	\$600 Copayment per admission \$35 Copayment per visit

PHARMACEUTICAL BENEFITS	COVERAGE
<b>COVERED PRESCRIPTION DRUGS<sup>1</sup>:</b>	
<ul style="list-style-type: none"> <li>• <b>Tier 1 (Generic Drugs)</b> <ul style="list-style-type: none"> <li>▪ From a Participating Pharmacy</li> <li>▪ Mail-Order</li> <li>▪ Participating Pharmacy</li> </ul> </li>   <li>• <b>Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)</b> <ul style="list-style-type: none"> <li>▪ From a Participating Pharmacy</li> <li>▪ Mail-Order</li> <li>▪ Participating Pharmacy</li> </ul> </li>   <li>• <b>Tier 3 (Non-Preferred Brand and Non-Preferred Generic Drugs)</b> <ul style="list-style-type: none"> <li>▪ From a Participating Pharmacy</li> <li>▪ Mail-Order</li> <li>▪ Participating Pharmacy</li> </ul> </li>   <li>• <b>Tier 4 (Biological Drugs, Biotechnical Drugs, and Specialty Pharmaceuticals<sup>3</sup> and Non-Preferred Drugs)</b></li>   <li>• <b>Oral Contraceptives</b></li>   <li>• <b>Diabetic Testing Supplies [OneTouch and Freestyle (excluding Libre) glucose meters, OneTouch and Freestyle glucose test strips, and any brand of lancets/lancet devices]</b></li> </ul>	<p>\$15 Copayment per 30-day supply \$38 Copayment per 90-day supply<sup>2</sup> \$45 Copayment per 90-day supply<sup>2</sup></p> <p>\$35 Copayment per 30-day supply \$88 Copayment per 90-day supply<sup>2</sup> \$105 Copayment per 90-day supply<sup>2</sup></p> <p>\$60 Copayment per 30-day supply \$150 Copayment per 90-day supply<sup>2</sup> \$180 Copayment per 90-day supply<sup>2</sup></p> <p>90% Coverage</p> <p>Covered (subject to above Copayments)</p> <p>100% Coverage</p>

<sup>1</sup>Some medications may require prior authorization from VIVA HEALTH. For further information, please contact Customer Service at the phone number listed below. <sup>2</sup>A 90-day supply is as written by the provider, unless adjusted based on the drug manufacturer’s packaging size, or based on supply limits. <sup>3</sup>May be administered in the home, physician’s office or on an outpatient basis. There is a Member out-of-pocket maximum of \$10,000 per Member per Calendar Year for biological drugs, biotechnical drugs, and specialty pharmaceuticals. When these medications are received from Express Scripts, they must be ordered by calling 1-800-803-2523. For a list of medications in this category, please refer to <https://www.vivahealth.com/Group/Login/>.

**When generic is available, Member pays difference between generic and brand price, plus Copayment.  
Check with your participating pharmacy to learn if it offers a 90-day supply at retail.**

**VIVA HEALTH Customer Service: (205) 558-7474 or 1-800-294-7780 | Visit our Website at [www.vivahealth.com](http://www.vivahealth.com)**

**Pre-Existing Condition Policy:** No pre-existing condition exclusions or waiting period.  
**Eligible Dependent:** Eligible Employee’s lawful spouse and children of Eligible Employee up to age 26 and disabled dependents who meet eligibility criteria.

VIVA HEALTH believes this health plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on the dollar value of essential health benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to VIVA HEALTH Customer Service at (205) 558-7474 or 1-800-294-7780. You may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov). For plans subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.